

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

Michael V. Pellicano
(Enter above the full name of plaintiff in this
action)

v.

The Office of Personnel Management,
Insurance Operations
(Enter above the full name of the defendant(s)
in this action)

CIVIL CASE NO:

11-405
(to be supplied by Clerk
of the District Court)

**FILED
SCRANTON**

MAR 02 2011

Per 
DEPUTY CLERK

COMPLAINT

1. The plaintiff Michael V. Pellicano a citizen of
the County of Lackawanna State of
Pennsylvania, residing at 209 E. Line St., Olyphant, PA 18447
wishes to file a complaint under _____
(give Title No. etc.)

2. The defendants are The Office of Personnel Management, Insurance Operations, 1900 E.
St., NW, Washington DC 20415

3. STATEMENT OF CLAIM: (State below the facts of your case. If you have paper
exhibits that give further information of your case, attach them to this completed form. Use as
much space as you need. Attach extra sheet(s) if necessary)

I Michael Vincent Pellicano hereby file a civil complaint against The Office of Personnel
Management Insurance Operations 1900 E. Street, NW Washington, DC 20415. The Office of Personnel
Management breached fiduciary duties was arbitrary and capricious in denying additional benefits. In
addition, they failed to notify me of their decision within the required 60 days. I seek reimbursement of
additional benefits in amount of \$7,243.95 plus any expenses incurred by me in pursuit of this action.

The Office Of Personnel Management, Insurance Operations failed to notify me of their decision
within 60 days as stated in the Plan brochure per page 108 (**enclosure 1**) . A copy of USPS
documentation (**enclosure 2**) will show the Office of Personnel Management received this request for
review on December 9, 2009. I did not receive decision until April 23, 2010 (**enclosure 3**). In addition Ms.
Isaac, (Insurance Benefits Claim Examiner for The Office of Personnel Management), stated in April 23,

2010 decision letter, "The Plan's brochure is the official statement of benefits for the BC BS Service Benefit Plan. The Plan is required to administer benefits according to the definitions, limitations, and exclusions set forth in the plan brochure. As stated in paragraph 2 of her decision letter as well as page 119 of the 2008 plan brochure (enclosure 4), "for physicians and other healthcare professional that do not contract with your local BC BS, our allowance is equal to or greater of 1 (the Medicare participating fee schedule amount for that service or supply in the geographical area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2 (100% of the 2008 Usual, Customary and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained." Ms. Isaac states in the same paragraph, "However, CareFirst BC BS policy is to provide benefit at 65% of the billed amount when there is no established allowance." Per Ms. Dean's, Federal CareFirst Blue Cross Blue Shield Maryland Reconsideration Specialist, decision letter September 23, 2009 (enclosure 5) CareFirst was advised by medical review to pay benefits at 65%, there was no policy referenced. When questioned as to how 65% was arrived at, Ms. Dean stated she did not know and never mentioned any policy. Ms. Isaac provided further contradicting evidence in paragraph 3, "You are requesting the plan to provide additional benefits because the plan brochure supports the use of 100% of the billed amount as the Plan Allowance and because the UCR for other BC BS FEP (Federal Employees Program) members have been 100% of the submitted charges for the DME equipment in question." After making the previous statement, Ms. Isaac then states, in paragraph 3, "There is not a UCR or Medicare fee schedule amount for the DME in question." CareFirst BC BS breached their fiduciary duties, were arbitrary and capricious by providing benefits at 100% of the billed amount as the plan allowance/UCR for the DME in question for other members, (Enclosure #6), then denying the same for my claim. OPM breached its fiduciary duties and was arbitrary and capricious in its decision as administrators of the FEHBP.

4. WHEREFORE, plaintiff prays that

the court find in his favor he be reimbursed additional benefits in the amount of \$7243.95 plus any expenses incurred by him in pursuit of this action.

Enclosures

Michael V. Belluino
by Susan T. Belluino POA
(Signature of Plaintiff)

List of Enclosures

Enclosure 1: page 108 2008 BCBS plan brochure

Enclosure 2: USPS documentation

Enclosure 3: April 23, 2010 OPM decision letter

Enclosure 4: page 119 2008 BCBS plan brochure

Enclosure 5: CareFirst Maryland BC BS approval 9/23/09

Enclosure 6: Copies of BC/BS documentation approving payment at 100% of submitted charges as plan allowance/UCR for other members

~~page 109 plan brochure~~

Page 108 section 8#5 2008 plan brochure

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against

OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

Washington, DC 20415

Human Resources
Products and Services
Division

December 16, 2009

R58740375

MR MICHAEL V PELLICANO
209 E LINE STREET
OLYPHANT PA 18447

Dear Mr. Pellicano:

This is in response to your request for an administrative review of your health benefits dispute with the Blue Cross and Blue Shield Service Benefit Plan. We have assigned **control number Y09350005** to your case. Please include this number with any future correspondence related to this appeal.

As part of our review process, we ask your health insurance carrier for a full report. We will provide our decision to you in writing when our review is completed. Also, please notify this Office if you receive any additional information from Blue Cross and Blue Shield concerning this matter.

We appreciate your patience during our review period. Thank you for your inquiry and cooperation in this matter.

Sincerely,

Cynthia M. Thomas
Customer Service Specialist
Insurance Services ProgramsI received
12/23/09

(202-606-0727)

1756 109 2008 10 10 10 10

Re: 60 day response

Mr. Michael V. Pellicano
209 E Line St
Olyphant, PA 18447

PAGE 2 OF 10

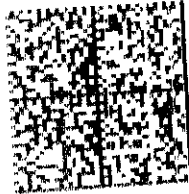
UNITED STATES
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WASHINGTON, DC 20415

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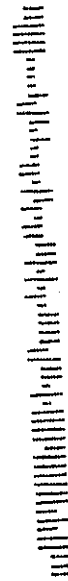
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12/19/2009

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JARH331 18447



Mr. Michael V. Pellicano
209 F Line St
Olyphant, PA 18447

ENCLOSURE # 2
PAGE 3 OF 10

SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 		<p>A. Signature <input checked="" type="checkbox"/> C. Thomas <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p>	
<p>1. Article Addressed to:</p> <p>US Office of Personnel Mgmt</p> <p>INSURANCE PROGRAMS HEALTH INS GROUP ONE 1900 E. STREET NW WASHINGTON DC 20415-3610</p>		<p>B. Received by (Printed Name) C. Thomas C. Date of Delivery 12/16/09</p>	
		<p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If YES, enter delivery address below:</p>	
		<p>3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>	
		<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>2. Article Number (Transfer from service label)</p>		<p>7008 1830 0002 5382 0241</p>	
<p>PS Form 3811, February 2004</p>		<p>Domestic Return Receipt 102595-02-M-1540</p>	

Mr. Michael V. Pellicano
209 E. Line St
Olyphant, PA 18447

ENCLOSURE # 2


PAGE 4 OF 10

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT SERVICES PROGRAM
WASHINGTON, DC 20415

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, \$300

RI-50-81
REVISED MARCH 2008
PREVIOUS EDITION IS USABLE.

10447 JAFHSG1

 Mr. Michael V. Pellicano
209 E Line St
Olyphant, PA 18447

12/19/09

Postmarked

209 East Line Street
Olyphant, PA 18447
December 2, 2009

12/3/09
mailed

ENCLOSURE # 2
PAGE 5 OF 10

United States Office of Personnel Management
Insurance Services Programs
Health Insurance Group One
1900 E Street, NW
Washington, DC 20415-3610

Re: Insured: Michael Pellicano
Date of Birth: 12/14/58
Member ID: R58740375
Claim #: 91149680EAF
Date of Service: 12/17/08
Case #: 0918714936

To Whom It May Concern:

I am hereby filing an appeal for additional benefits on the above-referenced claim in response to the September 23, 2009 letter (copy enclosed) from Michelle Dean, Reconsideration Specialist, Federal Employee Program.

Per Page 119 of the 2008 Service Benefit Plan Brochure, under the section titled **Non-participating Providers**, Paragraph 3, "...our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 100% of the 2008 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained." As there is no Medicare fee schedule for this service/supply, the greater of 60% of the billed charge or 100% of the UCR would be **"100% of the UCR."** This DME is only supplied by one provider, in one state: RTI in Maryland. The UCR amount used as the NPA for other BCBS Federal Employee Program Members for this DME has been 100% of the submitted charges, as evidenced by the enclosed EOB's. Per Michele Dean's September 23, 2009 letter, CareFirst was advised by medical review to pay the claim using 65% of the billed charge as the Plan Allowance. Although I questioned the use of 65% of the submitted charges as the UCR, I was given no explanation, and there is nothing to substantiate its use as the UCR in the Plan Brochure.

Please note that the reason for the difference in submitted charges for previous members' claims and those stated on my claim are due to the fact that the previous members' claims were for the RT300 leg cycle, whereas my claim, approved by CareFirst, is for the RT300 leg cycle with the arm cycle attachment.

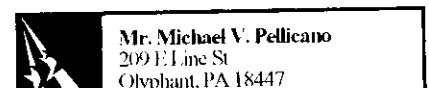
Because the Plan Brochure supports the use of 100% as the plan allowance (as stated above) and because the UCR for other BCBS Federal Employee Program Members has been 100% of the submitted charges for this DME, I believe that I, too, should be reimbursed at 100% of the submitted charges which are stated on my enclosed EOB.

Sincerely,

Michael Pellicano
(Phone #: 570-489-1057)
By Susan Pellicano, POA

Enclosures

Copy of 9/23/09 Letter from M. Dean (3 pages)
Copy of Page 119 of 2008 Plan Brochure
Copy of my EOB processed on 9/22/09
My 3/6/09 Letter of Request for Reconsideration of Decision (3 pages)
Copies of EOB's and Payment Checks of Other Claimants for RTI DME (4 pages)



PAGE 6 OF 10

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Mr. Michael V. Pellicano
209 E Line St
Olyphant, PA 18447

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- **Arrival at Unit, December 09, 2009, 10:18 am, WASHINGTON, DC 20022**
- **Acceptance, December 03, 2009, 3:52 pm, OLYPHANT, PA 18447**

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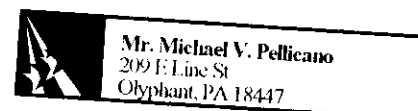
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209 E Line St
Olyphant, PA 18447

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I. Beale

Signature:	<input checked="" type="checkbox"/> Signature <input type="checkbox"/> Printed name	 I. Beale 12/9/09
Address:	<input checked="" type="checkbox"/> Delivery point <input type="checkbox"/> Street address	20415

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Mr. Michael V. Pellicano
209 E Line St
Olyphant, PA 18447

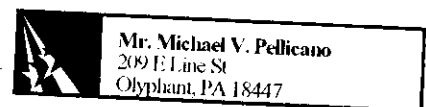
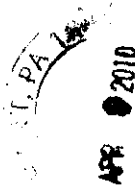
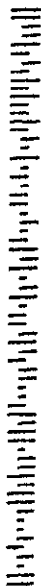
UNITED STATES
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MICHAEL V PELLICANO
209 EAST LINE STREET
OLYPHANT PA 18447

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ENCLOSURE # 3

PAGE 1 of 1



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

Washington, DC 20415

Human Resources
Products and Services
DivisionMICHAEL V PELLICANO
209 EAST LINE STREET
OLYPHANT PA 18447

FEB 22 2010

Dear Mr. Pellicano:

We have completed our review of your health benefits claim dispute (Y09350005/R58740375) with the Blue Cross and Blue Shield (BCBS) Service Benefit Plan (hereafter, Plan). The dispute concerns the Plan's level of benefits applied for a Functional Electrical Stimulation (FES) Cycle Ergometer. Restorative Therapies, Inc., a Non-participating provider, provided the durable medical equipment (DME) on December 17, 2008, totaling \$20,697.00. After review of your appeal, we concur with the Plan's decision.

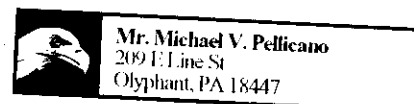
The Plan's brochure is the official statement of benefits for the BCBS Service Benefit Plan. The Plan is required to administer benefits according to the definitions, limitations, and exclusions set forth in the brochure. Our review process examines the Plan's actions to ensure that the Plan administered benefits according to the contract guidelines. As indicated on page 119 of the 2008 brochure, for physicians and other health care professional that do not contract with your local BCBS, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there no equivalent Medicare fee schedule amount) or 2) 100% of the 2008 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. However, CareFirst BCBS policy is to provide benefits at 65 percent of the billed amount, when there is no established allowance. The billed amount by the provider is \$20,697.00, the Plan provided benefits at 65 percent of the billed charges. You are responsible for the remaining balance of \$7,243.95.

You are requesting the Plan to provide additional benefits because the Plan brochure supports the use of 100 percent of the billed amount as the Plan allowance and because the UCR for other BCBS FEP members has been 100 percent of the submitted charges for the DME equipment in question. There is not a UCR or Medicare fee schedule amount for the DME in question. Therefore, the Plan provided benefits as indicated above. Also, we cannot direct the Plan to provide benefits based on information that you submitted of other BCBS enrollees. Our decision is based solely on the Plan's contract and its application to your disputed claim. Benefits were administered in accordance with the contract guidelines; therefore, we cannot direct the Plan to provide additional benefits. This is our final administrative review of this disputed claim. If you disagree with our decision, you may file suit against the Office of Personnel Management in Federal court.

Sincerely,

Debra Isaac
Insurance Benefits Claims Examiner
Insurance Operations

cc: CareFirst BCBS, BCBSA



Page 119 2008 plan brochure

For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 100% of the 2008 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");



Mr. Michael V. Pellicano
209 E Line St
Olyphant, PA 18447

CareFirst BlueCross BlueShield
Federal Employee Program
P.O. Box 14111
Lexington, KY 40512-4111



September 23, 2009

Michael V. Pellicano
209 E. Line Street
Olyphant, PA 18447-2026

Patient: Michael
Date of Birth: 12/14/58
Member ID: R58740375
Claim Number: 91149680EAF
Date of Service: 12/17/08
Case Number: 0918714936

Dear Mr. Pellicano:

This letter is in response to your recent request for reconsideration regarding the processing of a claim for durable medical equipment provided to you on 12/17/08. This service was provided by Restorative Therapies, Inc., which is a Non-participating provider group. Your concerns to clarify the processing of the claim will be addressed in the following paragraphs.

As stated on page 6 of the 2008 Service Benefit Plan brochure, this Plan has established Preferred provider organization (PPO) arrangements. PPO benefits apply only when you use a PPO provider and the availability of every specialty in all areas cannot be guaranteed. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

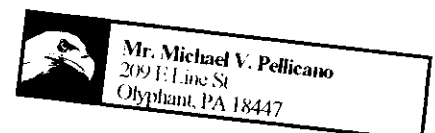
As stated on page 103 of the same brochure, under General exclusions, we do not provide benefits for services, drugs, or supplies that are not medically necessary or not specifically listed as covered.

As stated on page 111 of the same brochure, we waive some costs if the Original Medicare Plan is your primary payer. When Medicare Part B is primary, under Standard Option, we waive our:

- Calendar year deductible;
- Coinsurance for services and supplies provided by physicians and other covered health care professionals (inpatient and outpatient, including mental conditions and substance abuse care);
- Copayments for office visits to Preferred physicians and other health care professionals;
- Copayments for routine physical examinations and preventive (screening) services performed by Preferred physicians, other health care professionals, and facilities; and
- Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions and substance abuse care.

As stated on page 117 of the same brochure, durable medical equipment (DME) is equipment and supplies that:

1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury.



CareFirst BlueCross BlueShield
Federal Employee Program
P.O. Box 14111
Lexington, KY 40512-4111



As stated on page 118 of the same brochure, under Medical necessity, we determine whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are:

1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury;
2. Consistent with standards of good medical practice in the United States;
3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

As stated on page 119 of the same brochure, the Non-Participating Provider Allowance (NPA) is defined as an allowance equal to the greater of the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 100% of the 2008 Usual, Customary and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained.

In your letter you stated that benefits should be provided for the RT300 system due to your medical condition. The additional information you provided with your letter included a copy of Medicare's decision upholding their denial. This information is appreciated for an accurate review of the claim. We also requested the following information from the following providers:

Allied Services Rehabilitation Hospital, Stacy Cox, PT, DPT; Kennedy Krieger Institute, Dr. John McDonald; Kessler Institute in New Jersey, Dr. Mylan Lam; Physicians Health Alliance Inc.; Internal Medicine Family Practice; Dr. Joseph Greco; Dr. Claudia Jordan; and Dr. Shirish Bhatt:

- All medical records including the initial history and physical, office records, evaluations, and diagnostic tests and results

In addition, you indicated on the Member Request for Assistance letters that Dr. Mark Reilly, Dr. James Harrop, and Dr. Jonathan Burns have treated you for the condition on the disputed claim. Therefore, we requested the following information from them:

- All medical records including the initial history and physical, office records, evaluations, and diagnostic tests and results

We received the requested information from Allied Services Rehabilitation Hospital, Stacy Cox, PT, DPT, Dr. Joseph Greco, Dr. Mark Reilly, and Dr. James Harrop. We received a letter from Dr. John McDonald of Kennedy Krieger Institute indicating that he does not have any medical records to supply because you were never seen by him.

We forwarded the medical documentation received by Allied Services Rehabilitation Hospital, Stacy Cox, PT, DPT, Dr. Joseph Greco, and Dr. Mark Reilly to our Medical Review Department to determine if benefits could be provided for the RT300 system. Based upon this review, it was determined that this item meets the criteria for covered durable medical equipment. In addition, it was determined that this item was medically necessary for your condition as it was appropriate to treat your condition, illness, or injury and consistent with standards of good medical practice in the United States. Please make note that we did not receive medical records from Dr. James Harrop until after the medical review decision was made. Therefore, his records were not taken into account when the decision was made to provide benefits.



CareFirst BlueCross BlueShield
Federal Employee Program
P.O. Box 14111
Lexington, KY 40512-4111



Consequently, benefits were provided on new claim number 91874936EAF. Please make note that we were advised by medical review to pay the claim using 65% of the billed charge as the Plan allowance. Since Medicare Part B was your primary insurance, we waived our coinsurance and paid benefits at 100% of the Plan allowance. Check number 000008 in the amount of \$13,453.05 was issued to you today. Your total responsibility for this claim is \$20,697.00.

You have the right to appeal this decision and may do so by writing to the U.S. Office of Personnel Management at the address appearing below. Your appeal must be submitted within 90 days of the date of this letter and must indicate why, based on specific benefit provisions of the BCBS Service Benefit Plan brochure, you believe that additional benefits should be provided. Your appeal letter must identify the specific claim(s) or services in question and must include a copy of the benefits determination (e.g. Explanation of Benefits, letter denying precertification or prior approval), a copy of your letter to our office requesting reconsideration, a copy of this letter, copies of the documents that support your appeal and your daytime telephone number. Mail your appeal to:

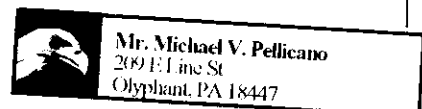
United States Office of Personnel Management
Insurance Services Programs
Health Insurance Group One
1900 E Street, NW
Washington DC 20415-3610

If you have any further questions regarding the appeals process, please contact us at 1-800-638-6756.

Sincerely,

Michelle Dean

Michelle Dean
Reconsideration Specialist
Federal Employee Program





Explanation of Benefits
THIS IS NOT A BILL

CAREFIRST BLUECROSS BLUESHIELD
POST OFFICE BOX 811
OWINGS MILLS, MARYLAND 21117
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TDD (410) 998-5500 (800) 892-1771

WWW.CAREFIRST.COM



EXPLANATION OF BENEFITS AT A GLANCE

Benefit Check Enclosed

Patient Name: [REDACTED]

Dates of Service: 7/07/2006 - 7/07/2006

You Owe the Provider: \$14,950.00

ID Number: [REDACTED]

Claim Number: [REDACTED]

Claim Paid On: 7/31/2007

Claim Received On: 7/17/2007

Claim Processed On: 7/30/2007

Check Number: [REDACTED]

Provider: RESTORATIVE THERAPIES
Type: NON-PARTICIPATING PROVIDER

Dates of Service: 7/07/2006 - 7/07/2006

Type of Service	Submitted Charges	Plan Allowance	Remark Codes	Deductible	Coinsurance	Medicare/Or Copay	Other Ins.	What We Paid	You Owe the Provider
MEDICAL EQUIP/SUPPLY	14,950.00	14,950.00	408			2,000.00		12,950.00	14,950.00
TOTALS:	\$14,950.00	\$14,950.00		\$0.00	\$2,000.00		\$0.00	\$12,950.00	\$14,950.00

EXPLANATION OF REMARK CODES

408--THE CATASTROPHIC PROTECTION MAXIMUM WAS MET ON THIS CLAIM OR A PREVIOUS CLAIM. AS A RESULT, NO FURTHER CALENDAR YEAR DEDUCTIBLE, PRESCRIPTION DRUG DEDUCTIBLE, COINSURANCE OR COPAYMENT WILL APPLY FOR THIS PATIENT FOR THIS CALENDAR YEAR.

YOUR RESPONSIBILITY TO THE PROVIDER(S) IS \$14,950.00. WE PAID \$12,950.00. THE PROVIDER CAN COLLECT \$14,950.00 FROM YOU FOR THESE SERVICES.

Summary of Out-of-Pocket Expenses for 2006

What You Have Paid	Calendar Year Deductible	Catastrophic Protection	
		Preferred	Non-Preferred/Preferred Total
Individual	\$250.00	\$0	\$0
Family	\$500.00	\$4,000	\$6,000
Annual Maximum			
Individual	\$250.00	\$0	\$0
Family	\$500.00	\$4,000	\$6,000

Your Out-of-Pocket Expenses On This Claim	
Calendar Year Deductible	\$0.00
Per Admission Copay	\$0.00
Coinsurance	\$2,000.00
Copayment	\$0.00
Non-covered Charges	\$0.00
Precertification Penalty	\$0.00
TOTAL:	\$2,000.00

If you have questions, please call a customer service representative at your local Blue Cross and Blue Shield Plan. If you disagree with the decision on your claims or request for services, and wish to have the decision reconsidered, you must notify your Plan in writing within 6 months from the date of this decision. See the Disputed Claims Section of your Service Benefit Plan Brochure.



Mr. Michael Pellicano
209 E. Line St.
Olyphant, PA 18447

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MAILROOM ADMINISTRATOR
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TDD (410) 998-5500 (800) 892-1771
WWW.CAREFIRST.COM

EXPLANATION OF BENEFITS AT A GLANCE

Benefit Check Enclosed	ID Number: R [REDACTED]
Patient Name: [REDACTED]	Claim Number: [REDACTED]
Dates of Service: 06/02/2008 - 06/02/2008	Claim Paid On: 07/25/2008
You Owe the Provider: \$14,950.00	Claim Received On: 06/23/2008
	Claim Processed On: 07/24/2008
	Check Number: [REDACTED]

Provider: RESTORATIVE THERAPIES
Type: NON-PARTICIPATING PROVIDER

Dates of Service: 06/02/2008 - 06/02/2008

Type of Service	Submitted Charges	Plan Allowance	Remark Codes	Deductible	Coinsurance Or Copay	Medicare/Other Ins.	What We Paid	You Owe the Provider
MEDICAL EQUIP/SUPPLY	14,950.00	14,950.00	408		3,316.48		11,633.52	14,950.00
TOTALS:	\$14,950.00	\$14,950.00		0.00	\$3,316.48	\$0.00	\$11,633.52	\$14,950.00

EXPLANATION OF REMARK CODES

408--THE CATASTROPHIC PROTECTION MAXIMUM WAS MET ON THIS CLAIM OR A PREVIOUS CLAIM. AS A RESULT, NO FURTHER CALENDAR YEAR DEDUCTIBLE, PRESCRIPTION DRUG DEDUCTIBLE, COINSURANCE OR COPAYMENT WILL APPLY FOR THIS PATIENT FOR THIS CALENDAR YEAR.

YOUR RESPONSIBILITY TO THE PROVIDER(S) IS \$14,950.00. WE PAID \$11,633.52. THE PROVIDER CAN COLLECT \$14,950.00 FROM YOU FOR THESE SERVICES.

Summary of Out-of-Pocket Expenses for 2008

What You Have Paid	Calendar Year Deductible	Catastrophic Protection		Your Out-of-Pocket On This Claim
		Preferred	Non-Preferred/ Preferred Total	
Individual	\$300.00	\$3,133	\$6,500	Calendar Year Deductible
Family	\$0.00	\$0	\$0	Per Admission Copay
Annual Maximum				Coinsurance
Individual	\$300.00	\$4,500	\$6,500	Copayment
Family	\$0.00	\$0	\$0	Non-covered Charges
				Precertification Penal
				TOTAL:

If you have questions, please call a customer service representative at your local BlueCross BlueShield Plan. If you disagree with the decision on your claims or request for services, and wish to have the decision reconsidered, you must notify your Plan in writing within 6 months from the date of this decision, e.g. 01/25/2009. Your Plan will not accept unauthorized reconsiderations from providers. See the Disputed Claims Section of your Service Benefit Plan Brochure.



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